Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA, TX 77504

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-05-8974-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Hospital of Dallas charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista is at a minimum of 70% of billed charges. This is supported by a managed care contract with "Focus". This contract between Vista and Focus exemplifies that reimbursement was provided to Vista at 70% pursuant to that contract for other claimants from other carriers. This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and *at the very minimum,* 70% of the usual and customary charges is fair reasonable. This managed care contract exhibits that Vista Hospital of Dallas is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for outpatient medical services. As a result, the reimbursement requested by Vista Hospital of Dallas is not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract."

Amount in Dispute: $35,624.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier reimbursed the requester a fair and reasonable reimbursement for code 29873 using exception code "M" on the explanation of benefits. This carrier's position remains thata fair and reasonable reimbursement was made and no additional benefit is due."

Response Submitted by: Texas Mutual Insurance Company, 221 W. 6th St., Ste 300, Austin, TX 78749

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2004	Outpatient Surgery	$35,624.40	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. This request for medical fee dispute resolution was received by the Division on May 24, 2005.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 17, 2004
   - E – Entitlement to benefits.
   - YE – The carrier is disputing the liability of the claim or compensability of the injury. This has not been determined final through adjudication.

   Explanation of benefits dated September 10, 2004
   - O – Denial after reconsideration.
   - YE – The carrier is disputing the liability of the claim or compensability of the injury. This has not been determined final through adjudication.
   - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
   - E – Entitlement to benefits.

   Explanation of benefits dated June 16, 2005
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - CAC-W2 – Workers' Compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
   - CAC-150 – payment adjusted because the payer deems the information submitted does not support this level of service.
   - 245 – The carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place.
   - 282 – The insurance company is reducing or denying payment after reconsidering a bill.
   - 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution

pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/10/12
Signature	Medical Fee Dispute Resolution Officer	Date
		1/10/12
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.